98TH CONGRESS
2D SESSION

H. R. 4870

To provide for the solvency of the medicare program and to reform the health care financing system.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 21, 1984

Mr. GEPHARDT (for himself, Mr. FAUNTROY, Ms. FERRARO, Mr. GRAY, Mr. KASTENMEIER, Mr. LELAND, Mr. MARKEY, Ms. MIKULSKI, Mr. RATCHFORD, Mr. RODINO, Mr. SABO, Mr. SHANNON, Mr. STOKES, Mr. TORRES, Mr. TOWNS, and Mr. YATES) introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

---

A BILL

To provide for the solvency of the medicare program and to reform the health care financing system.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE AND TABLE OF CONTENTS OF ACT

SECTION 1. This Act may be cited as the "Medicare Solvency and Health Care Financing Reform Act of 1984".

TABLE OF CONTENTS

Sec. 1. Short title and table of contents of Act.
Sec. 2. Programs for reforming the health care financing system.

"TITLE XXI—PROGRAMS FOR REFORMING THE HEALTH CARE FINANCING SYSTEM

"PART A—STATE HEALTH CARE PROGRAMS

"Sec. 2101. Increased Federal medical assistance percentage and temporary exemption from Federal limits for States indicating an intention to submit a State health care plan.
"Sec. 2102. State health care plans.
"Sec. 2103. Requirements of State health care plans.

"PART B—RESIDUAL FEDERAL PROGRAM

"Subpart I—Transition Period

"Sec. 2121. Prospective payment for private payors.
"Sec. 2122. Establishment of prospective payment limits for discharges classified by diagnosis-related groups.
"Sec. 2123. Exceptions.
"Sec. 2124. Civil penalty.
"Sec. 2125. Improper admissions practices.
"Sec. 2126. Administration of subpart.

"Subpart II—Post-Transition Period

"Sec. 2131. Federal administration of State health care programs.

"DEFINITIONS AND COMPETITIVE PROVISIONS

"Sec. 2141. Definitions.
"Sec. 2142. Review of technologies and procedures.
"Sec. 2143. Exceptions for health maintenance organizations and competitive medical plans.
Sec. 3. Health maintenance organization and competitive medical plan provisions.
Sec. 4. Medicare payment provisions.
Sec. 5. Requiring payments for health care service furnished to inpatients to be made to or through a hospital as a condition of the hospital's participation in the medicare program.
Sec. 6. Payments from medicare trust funds.
Sec. 7. Studies.

PROGRAMS FOR REFORMING THE HEALTH CARE FINANCING SYSTEM

SEC. 2. The Public Health Service Act is amended by adding at the end thereof the following new title:

"TITLE XXI—PROGRAMS FOR REFORMING THE HEALTH CARE FINANCING SYSTEM

"PART A—STATE HEALTH CARE PROGRAMS

"INCREASED FEDERAL MEDICAL ASSISTANCE PERCENTAGE AND TEMPORARY EXEMPTION FROM FEDERAL LIMITS FOR STATES INDICATING AN INTENTION TO SUBMIT A STATE HEALTH CARE PLAN

"SEC. 2101. (a) If the chief executive officer of a State transmits to the Secretary, not later than one year after the date of the enactment of this title, a statement indicating that the State intends to submit a State health care plan described in section 2102, for purposes of making payments to such a State under section 1903 of the Social Security Act (and notwithstanding any other provision of title XIX of such Act) the Federal medical assistance percentage shall be 102 per centum of the Federal medical assistance percentage otherwise determined under section 1905(b) of such Act for that State for up to four calendar quarters beginning with calendar quarters after the date such notice is provided.

"(b) The Secretary shall exempt hospitals in a State from the prospective payment limits established under subpart I of part B for portions of accounting periods occuring during the first year of the transition period (as defined in section 2141(7)) if—

"(1) the chief executive officer of the State requests such treatment,

"(2) such officer indicates an intention to have implemented (not later than the end of the first year of the transition period) a State plan under this part, which will provide for a recoupment of any revenues received in excess of the amounts permitted under this part, and

"(3) the officer has agreed, with respect to such hospitals, that if a State plan under this part is not implemented by the end of the first year of the transition period, then the Secretary shall provide for such adjustment in the prospective payment limits under subpart I of part B as will provide for recoupment in the subsequent year of any revenues received in excess of the amounts permitted under that part.

"STATE HEALTH CARE PLANS

"SEC. 2102. (a)(1) The chief executive officer of any State may apply to the Secretary for the approval of a health care plan for that State for an initial period of up to thirty-six months, subject to disapproval under subsection (d). The officer may apply for an extension of such initial period for up to an additional twenty-four months in accordance with subsection (d)(3)(B).

"(2) The Secretary, upon request of the chief executive officer of a State, may provide technical assistance to the State in the preparation of a health care plan for approval under this part.

"(b)(1) The Secretary shall approve an application for a plan if the Secretary determines that the plan meets the applicable requirements of section 2103. The Secretary shall approve or disapprove the application within sixty days after the date the application is submitted.

"(2) If the Secretary does not approve a plan, the Secretary shall provide the State with a notice of the reasons why the plan may not be approved and an opportunity for a hearing on such disapproval.

"(c) In the case of any State with a plan approved under subsection (a) for any twelve-month period—

"(1) the provisions of subpart I of part B of this title shall not apply to accounting periods (or portions thereof) to which such plan applies;

"(2) the Secretary shall waive requirements for reimbursement (other than those relating to beneficiary cost sharing) under title XVIII of the Social Security Act for services furnished in such a State and covered under the plan during the twelve-month period; and

"(3) for purposes of making payments to such a State under section 1903 of the Social Security Act

(and notwithstanding any other provision of title XIX of such Act) the Federal medical assistance percentage for that State shall—

"(A) for each calendar quarter ending in the first twelve-month period in which the plan is in effect, be 103 per centum (or 104 per centum in the case of an unrestricted medicaid plan) of the amount of the Federal medical assistance percentage otherwise determined under section 1905(b) of such Act, and

"(B) for each calendar quarter ending in any subsequent twelve-month period (except any extension period under subsection (d)(3)(B)), be 102 per centum (or 103 per centum in the case of an unrestricted medicaid plan) of the amount of the Federal medical assistance percentage otherwise determined.

For purposes of paragraph (3), the term 'unrestricted medicaid plan' means a State plan under title XIX of the Social Security Act which does not impose any limitation on the scope or duration of inpatient hospital services other than requiring that such services be medically necessary. Any increased Federal medical assistance percentage provided under paragraph (3) of this subsection for a calendar quarter

shall be instead of any increased percentage permitted with respect to that calendar quarter under section 2101.

"(d)(1) The Secretary shall annually review the compliance of each plan approved under this part with the requirement of section 2103(b).

"(2) If the Secretary determines that the State has not complied with the requirement for the previous twelve-month period, the Secretary shall continue approval of the plan for the following twelve-month period if the chief executive officer of the State certifies to the Secretary that the plan will be in compliance with such requirement for the twenty-four-month period beginning with that previous twelve-month period.

"(3)(A) If the Secretary determines that a State has not complied with the requirement for two consecutive twelve-month periods, the Secretary may, at the Secretary's discretion, continue approval of the plan for the following twelve-month period only if the chief executive officer of the State presents a credible plan for assuring that the State will be in compliance with such requirement for the thirty-six-month period beginning with the two previous consecutive twelve-month periods.

"(B) The Secretary may, at the Secretary's discretion, extend such thirty-six-month period for up to an additional twenty-four months but only if the Secretary finds that there

has been established a trend such that the State will be in compliance with the requirement for the sixty-month period beginning with the first date in which the plan is in effect. During any such extension period, there shall be no increase in the Federal medical assistance percentage for the State under subsection (c)(3)(B).

"(4) In the case of a State which has failed to meet such requirement for two consecutive twelve-month periods (or, in the case of a State described in paragraph (3), thirty-six-month or longer period), the Secretary shall establish a Federal program under section 2131 with respect to hospitals in that State in a manner that assures that by the end of the first twelve-month period of such Federal program the revenues for hospital inpatient services will be at a level consistent with that required under section 2103(b) if the State had been in compliance with that level in all previous periods.

"REQUIREMENTS OF STATE HEALTH CARE PLANS

"SEC. 2103. (a)(1) In order to be approved under this part, a State health care plan must meet the general requirements for all such plans described in subsections (b) and (c) and, if applicable, the requirements of subsection (d) (relating to ratesetting plans). In meeting the requirements of subsections (b) and (c), a plan may be designed in a manner that meets such requirements through a ratesetting system, a voluntary system, or through the use of competitive mechanisms

described in subsection (e). A plan may be designed so as to meet the requirements through different systems or mechanisms for different areas or hospitals within a State.

"(b)(1)(A) Except as provided in paragraph (3), the plan must be designed in a manner so as to provide, to the satisfaction of the Secretary, that—

"(i) the amount of the total revenues per discharge for inpatient hospital services for all hospitals in the State for each twelve-month period (beginning before 1987) in which the plan under this part is in effect may not exceed the base general hospital revenues per discharge (described in subparagraph (B)(i)) increased by the sum of (I) the compounded sum of the percentage limits computed under subparagraph (C) for that period and previous twelve-month periods for which the State plan under this part was in effect, and (II) the population-discharge factor described in subparagraph (D); and

"(ii) the amount of the total revenues per discharge for all services furnished to hospital inpatients for all hospitals in the State for each twelve-month period (beginning after 1986) in which the plan under this part is in effect may not exceed the sum of—

"(I) the base general hospital revenues per discharge (described in subparagraph (B)(i)) in-

creased by the sum of the compounded sum of the percentage limits computed under subparagraph (C) for that period and previous twelve-month periods for which the State plan under this part was in effect, and the population-discharge factor described in subparagraph (D), and

"(II) the base physician-related hospital revenues per discharge (described in subparagraph (B)(ii)) increased by the sum of the compounded sum of—

"(a) the percentage limits computed under subparagraph (C) for that period and previous twelve-month periods for which the State plan under this part was in effect and provided for a limitation under this clause (ii) (instead of under clause (i)) and

"(b) the population-discharge factor described in subparagraph (D);

except that a State may, at its option, apply the test specified in clause (ii) instead of the test specified in clause (i) with twelve-month periods beginning before 1986.

"(B) For purposes of subparagraph (A):

"(i) The 'base general hospital revenues per discharge' for a State is the average limitation on the amount of the revenues per discharge for inpatient hos-

pital services which was established for discharges of hospitals in the State under part B during the twelve-month period immediately preceding the first twelve-month period for which the plan is in effect, taking into account exceptions provided under section 2123, or, if such part was not in effect during that preceding twelve-month period, the average amount of the revenues per discharge for inpatient hospital services in the State during 1983 updated by the national average percentage increase in community hospital costs per discharge during the period between July 1, 1983, and the first day of the first twelve-month period for which the plan is in effect.

"(ii) The 'base physician-related hospital revenues per discharge' for a State is the average of the revenues per discharge of hospitals in the State for hospital inpatients (other than revenues attributable to inpatient hospital services taken into account under clause (i)) for the first year of the transition period, increased (for each year (or portion thereof) after such year and before the first twelve-month period in which the plan is in effect and provides for a limitation based on the test described in subparagraph (A)(ii)) by the percentage limit described in subparagraph (C).

"(C) For purposes of subparagraph (A), the 'percentage limit' is equal to such limit as established in accordance with the methodology established by the panel under subsection (c)(3)(B), but in no case may such limit exceed for a twelve-month period the applicable percentage limit described in subsection (b)(3)(B) of section 1886 of the Social Security Act (without regard to subsections (d) and (e) of that section) for that period.

"(D) For purposes of subparagraph (A), the 'population-discharge factor' for a State for a twelve-month period is the sum of—

"(i) the percentage increase or decrease in the population of individuals under sixty-five years of age in such State from the twelve-month period before the first twelve-month period in which the plan under this part is in effect in the State (or, in the case of the limitation described in subparagraph (A)(ii)(II), from the first twelve-month period before the first twelve-month period in which such limitation applies in the State to the twelve-month period before the twelve-month period involved, and

"(ii) one-half of the percentage by which the percentage increase (if any) in the number of hospital discharges of individuals under sixty-five years of age in such State during the period described in clause (i) ex-

ceeds the percentage increase or decrease described in such clause for that period.

The Secretary may adjust the percentage change described in clause (i) to take into account the net impact in hospital utilization in a State resulting from the use of hospital services in that State by individuals residing outside the State or resulting from a shift in hospital utilization by individuals residing in the State from utilization of hospitals outside the State to utilization of hospitals within the State, but only if, in making such adjustment, there is a corresponding adjustment made in the percentage change for the State in which such individuals reside.

"(2)(A) For purposes of this section—

"(i) in determining the revenues for inpatient hospital services of a hospital or the revenues for other services furnished to an inpatient of a hospital, except as provided in clauses (ii) and (iii) there shall be included all revenues (whether received by or through the hospital or any other entity) paid respecting the provision of inpatient hospital services or of other services, respectively, to the inpatient of the hospital;

"(ii) there shall be excluded from revenues for inpatient hospital services amounts paid in philanthropy or under research grants and contracts;

"(iii) except as provided in section 2143(c), there shall be excluded from revenues and discharges relating to services in a hospital amounts for such services paid by, and discharges attributable to, eligible organizations (as defined in section 2141(1));

"(iv) in establishing the base from which revenues are computed under a State system under this part for the first twelve-month period in which it is in effect, there shall be taken into account any reductions which would have otherwise been effected under section 2122(e)(1)(A) for portions of accounting periods of hospitals occurring during that period.

"(B) The plan may, with the approval of the Secretary, exempt revenues of hospitals and other persons from limits under the plan if—

"(i) the exemption is necessary to facilitate an experiment or demonstration entered into under section 402 of the Social Security Amendments of 1967 or section 1115 of the Social Security Act; and

"(ii) the experiment or demonstration is not inconsistent with the purposes of this title.

"(C) The plan must provide for such reports to the Secretary as the Secretary may require in order to monitor properly assurances provided under this section and the operation of the plan.

"(3) A plan under this subsection may, instead of meeting the requirements of paragraph (1), meet such other alternative test of constraint of health care costs as the Secretary determines will result in no greater expenditures of funds under title XVIII of the Social Security Act and by private payers than would have been made if the plan met the requirements of such paragraph.

"(4)(A) The plan must be designed in a manner so as to provide, to the satisfaction of the Secretary, that the amount of revenues for inpatient hospital services and physicians' services to hospital inpatients provided to individuals entitled to benefits under parts A and B of title XVIII of the Social Security Act, may not exceed the amount which would otherwise be payable (including copayments and deductibles) for such services under the provisions of such title.

"(B) A plan (other than a plan providing for the establishment of rates of hospital reimbursement for hospital inpatient services) may provide that payment under title XVIII of the Social Security Act for inpatient hospital services and for other services furnished to hospital inpatients shall continue to be made in the amounts and in the manner otherwise provided under such title.

"(c)(1)(A) The unreimbursed costs incurred by hospitals in providing services to patients (other than medicare or medicaid patients) who are of low income and are uninsured or

underinsured (as defined by the Secretary) shall be paid pursuant to the plan in the amount described in subparagraph (B) through distribution of funds pooled at the statewide level, through a higher payment rate, or through another method approved by the Secretary. If the plan provides for the determination of rates under a system described in subsection (d), payment of amounts to hospitals in a State under the previous sentence must be allocated among payors for inpatient hospital services in a manner that reflects the relative proportion of the payments for such services that are made by that payor (or class of payor), and shall be allocated among hospitals in proportion to the share of unreimbursed care provided by the hospital, except that—

"(i) the proportion of such amounts paid pursuant to title XVIII of the Social Security Act may not be greater than the proportion paid during the fiscal year before the first twelve-month period in which the plan is in effect (except to take into account any increase in the proportion of total revenues which are attributable to such title) and

"(ii) the proportion of such amounts paid pursuant to State plans approved under title XIX of such Act need not be greater than the proportion paid during the first year before the first twelve-month period in which the plan is in effect.

"(B) The amount provided to cover such unreimbursed costs (after reasonable efforts to collect debts) must, in the aggregate, be the same proportion of total revenues (including revenues from philanthropic payments and other sources of revenues other than revenues relating to research grants and contracts) as such unreimbursed costs are of total costs of patients who are neither medicare nor medicaid patients.

"(2)(A) The plan must have a mechanism for providing fair hearings for hospitals and any other entities aggrieved by determinations made under the plan.

"(B)(i) The plan must provide that any health planning or certificate of need law in the State (described in section 1527 of the Public Health Service Act) must provide for the exemption from the operation of such law of projects by or on behalf of health care facilities owned or controlled by, or serving predominantly individuals who are members of, eligible organizations (as defined in section 2141(1)).

"(ii) The plan may not provide for any limitation on the number of admissions or discharges which are attributable to members of eligible organizations.

"(C) The plan must assure that hospitals continue to meet Federal and State certification standards for quality of care.

"(D) The plan must provide for a method of assuring that hospitals do not engage in admissions practices prohibited during the transition period under section 2125.

"(3)(A) The chief executive officer of the State shall provide for the appointment of a panel, consisting of members with expertise in health care economics and service delivery consistent with subparagraph (C).

"(B) The panel shall advise in the development and implementation of the plan, periodically review and propose modifications to the plan, and establish the methodology for establishing a percentage increase to be used under subsection (b)(1)(C) under the plan. Such methodology shall include the use of appropriate external price indicators, the use of data from major collective-bargaining agreements for nonsupervisory hospital employees, and other appropriate indicators of wage costs. The Secretary shall approve the methodology and the percentage increase established by the panel under this subparagraph for goods and services other than the wages of nonsupervisory hospital employees unless the Secretary determines that the percentage increase exceeds, for any twelve-month period, the applicable percentage increase described in subsection (b)(3)(B) of section 1886 of the Social Security Act (without regard to subsections (d) and (e) of that section) for that period insofar as such increase is determined for goods and services other than wages of nonsu-

pervisory hospital employees. The Secretary shall approve the methodology and the percentage increase established by the panel under this subparagraph with respect to the wages of nonsupervisory hospital employees unless the Secretary determines that the methodology is arbitrary and capricious. Whenever the percentage increase established by the panel for the wages of nonsupervisory hospital employees for a twelve-month period deviates substantially from appropriately weighted indicators of actual changes in such wages for that period, the Secretary shall instruct the panel to adjust the methodology and percentage increase appropriately for the following twelve-month period.

"(C) The panel shall include at least—

"(i) one member selected from a list of qualified individuals submitted by unions that represent health care workers and another member selected from a list of qualified individuals submitted by unions that represent other workers;

"(ii) one member who represents employers who provide health coverage for their employees;

"(iii) one member who is a consumer of health care services and is not affiliated with the health care industry;

"(iv) one member who is a representative of third-party payors for health care services;

"(v) one member who is a representative from a hospital;

"(vi) one member who is a physician and another member who is a registered nurse;

"(vii) one member who is an independent public member and who shall serve as chairman; and

"(viii) one member who represents the interests of senior citizens or senior-citizen organizations.

"(d) To the extent that the plan provides for meeting the requirements of subsections (b) and (c) through a system which provides for the establishment of rates for hospital reimbursement for hospital inpatient services by an entity other than the hospital, the plan must meet the following additional requirements:

"(1) Except as provided in paragraph (2), the plan must be designed and administered in a manner that provides equitable treatment under the plan of all entities that pay for health services covered under the plan, of employees of hospitals, and of patients receiving such services.

"(2)(A) If the plan is established under State law, the plan must take into account (whether on a per diem, per discharge, or other basis) the proportion of costs associated with, and services covered by, the different payors, including the medicare and medicaid

programs, and may not permit undue shifting of proportions of costs among the different payors. Where there are large disparities among private payors in the amounts paid, the plan may provide for a phasing-out of the differences in payment amounts among such payors.

"(B) The plan may not make available any discount in price to any purchaser unless—

"(i) the discount is in an amount which accurately reflects identifiable and measurable economic benefits to that hospital resulting from a service or reimbursement arrangement with that purchaser, and

"(ii) the discount is made available to all other purchasers who can satisfy such service or reimbursement arrangement.

"(3) The plan must provide a procedure whereby, upon the request of a hospital, an adjustment can be considered to the rate limitation applicable under the plan to that hospital to reflect—

"(A) a significant change in the capacity or character of the inpatient hospital services available in the hospital or a major renovation or replacement of physical plant which has been approved by the State health planning and develop-

ment agency or the State planning agency designated for purposes of section 1122(b) of the Social Security Act, if either such agency exists;

"(B) funds necessary to provide for the efficient operation of the hospital if the hospital (i) is a sole community hospital or provides a disproportionate percentage of its services, in comparison with facilities of similar size and urban or rural location, to low-income patients, (ii) would otherwise be insolvent, and (iii) should be maintained in the judgment of the State health planning and development agency (or other appropriate State agency);

"(C) higher expenses associated with the special needs and circumstances (including greater intensity of care) of the hospital because it is a regional tertiary care institution, teaching hospital, or children's hospital; and

"(D) increased costs for compensation of employees, including collectively bargained increases, adjustments to remedy shortage of personnel, or other adjustments necessary to maintain a qualified staff,

but only if any change due to which the adjustment is sought is not inconsistent with any applicable State

health plan approved by the State health planning and development agency.

"(e) If the plan provides for control of hospital inpatient costs in whole or in part through a competitive mechanism, the Secretary shall, in reviewing the plan, take into account the degree to which the plan provides for the following or other measures to improve price competition among providers:

"(1) The plan provides for the establishment of one or more open enrollment periods permitting eligible individuals to elect to enroll, disenroll, or change the type of enrollment with private or public health benefits plans (whether providing prepaid care or otherwise).

"(2) The plan provides for the dissemination of such information concerning different health benefits plans (including benefit structure and premiums) to individuals eligible to enroll with the health benefits plans as may encourage informed decisionmaking and competition in price among the plans.

"(3) The plan encourages innovation and public incentives to new forms of health care delivery and financing.

"(4) There are negotiated prices and risk-sharing between insurers and health care providers.

"(5) The laws of the State do not impose legal barriers to competition in negotiated and other arrangements among insurers and health care providers.

"PART B—RESIDUAL FEDERAL PROGRAM

"Subpart I—Transition Period

"PROSPECTIVE PAYMENT FOR PRIVATE PAYORS

"SEC. 2121. (a) Subject to the provisions of this subpart, for any accounting period of a hospital subject to this subpart the total revenues for inpatient hospital services may not exceed the total of such revenues that are permitted on the basis of prospective payment limits which are established under this subpart for the hospital's discharges (as classified by diagnosis-related groups).

"(b)(1) Each hospital subject to a limitation on revenues under this subpart shall provide for the publication of a price list which establishes the price per discharge (classified in accordance with diagnosis-related groups) which any payor may pay for inpatient hospital services. Such price list may include an outlier policy to provide for variations in the prices with respect to particular discharges classified within a diagnosis-related group to reflect differences in the lengths of stay or other costs associated with those discharges.

"(2) A hospital may provide from time to time for revision and republication of such price list.

"(3) Each such hospital shall provide for transmittal to the Secretary of each price list published under this section.

"(4) Nothing in this subpart shall be construed as preventing a hospital from taking into account, in its establishment of such a price list, bad debts and charity care related to inpatient care.

"ESTABLISHMENT OF PROSPECTIVE PAYMENT LIMITS FOR DISCHARGES CLASSIFIED BY DIAGNOSIS-RELATED GROUPS

"SEC. 2122. (a) The Secretary of Health and Human Services shall determine (for any accounting period of each hospital subject to this subpart) a prospective payment limit for inpatient hospital services for discharges classified by diagnosis-related groups established under subsection (b)(1). Subject to the remaining provisions of this subpart, the limit shall be determined for each hospital for discharges as follows:

"(1) DETERMINATION OF REVENUE PER DISCHARGE BASE.—The Secretary shall determine for the hospital—

"(A) the ratio of (i) the total revenues for inpatient hospital services to (ii) the number of discharges, for the most recent accounting period ending before January 1, 1984, for which adequate data are available (hereinafter in this sub-

section referred to as the 'base accounting period'), and

"(B) the classification and weighting factors for such discharges according to diagnosis-related groups established under subsection (b).

"(2) STANDARDIZATION OF DRG-SPECIFIC BASE AMOUNTS.—The Secretary shall determine for the hospital a standardized average revenues for inpatient hospital services per discharge for the base accounting period by adjusting the ratio described in paragraph (1)(A) to eliminate any effect attributable to the differing weighting factors determined under paragraph (1)(B) for discharges in the base accounting period.

"(3) UPDATING AMOUNTS.—The Secretary shall update each amount determined under paragraph (2) by—

"(A) updating to the transition period by the national average percentage increase in community hospital costs per discharge during the period between the midpoint of the base accounting period used under paragraph (1) and the first day of the transition period, and

"(B) increasing to the accounting period involved by the compounded sum of the percentage limits (specified in subsection (d)(1)) for that ac-

counting period and previous accounting periods of the hospital to which this subpart applies.

"(4) COMPUTATION OF DRG-SPECIFIC MAXIMUM AVERAGE REIMBURSEMENT LIMITS.—For each hospital discharge classified within a diagnosis-related group, the Secretary shall compute a prospective payment limit equal to the product of—

"(A) the updated amount established under paragraph (3), and

"(B) the weighting factor (determined under subsection (b)(2)) for that diagnosis-related group.

"(5) ADJUSTMENT FOR CHANGES IN NUMBER OF DISCHARGES.—The Secretary shall adjust the hospital's prospective payment limits computed under paragraph (4) to take into account, in the manner described in subsection (e), a change in the number of discharges in the previous accounting period over a base number of discharges.

The Secretary shall notify each hospital of the prospective payment limits established under this section for each accounting period (or portion thereof) subject to the limits of this subpart and of the base number of discharges (established under subsection (e)(2)) for that hospital. Such notice shall, in the case of accounting periods beginning during the transition

period, be in advance of the beginning of that accounting period.

"(b) For purposes of this title the Secretary shall, taking into account classifications and weighting factors established under section 1886(d)(4) of the Social Security Act—

"(1) establish a classification of inpatient hospital discharges by diagnosis-related groups and a methodology for classifying specific hospital discharges within these groups, and

"(2) assign, to each such group, an appropriate weighting factor which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

The Secretary may, from time to time, adjust such classifications and weighting factors to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources.

"(c)(1)(A) This subpart shall not apply to accounting periods of a hospital ending before the first day of the transition period (as defined in section 2141(7)) or beginning after the date on which the hospital becomes subject to a program under part A.

"(B) In the case of an accounting period of a hospital that begins before the date on which the hospital becomes

subject to a program under part A and ends after such date, the Secretary shall provide that the limits established under this subpart shall apply in a manner so as to reflect the portion of the accounting period subject to this subpart.

"(2) For purposes of this subpart in determining the revenues for inpatient hospital services of a hospital, there shall be included all revenues (whether or not received by or through the hospital or any other entity) paid (whether to the hospital or to other entities) respecting the provision of inpatient hospital services to an inpatient of the hospital.

"(3) In computing revenues and discharges under this subpart for a hospital's accounting period (including the base accounting period), in establishing the national average percentage increase in community hospital costs per discharge under subsection (a)(3)(A), and in determining the national average percentage increase in discharges to community hospitals under subsection (e)(2), there shall not be included revenues and discharges attributable to inpatients who, on the date of their admission, were entitled to benefits under part A of title XVIII of the Social Security Act or medical assistance under a State plan approved under title XIX of such Act and there shall not be included revenues attritutable to philanthropy or to research grants and contracts.

"(4) The Secretary may provide for an adjustment to the prospective payment limits established under this subpart to the extent that the Secretary determines that—

"(A) the adjustment is necessary to facilitate an experiment or demonstration entered into under section 402 of the Social Security Amendments of 1967 or section 1115 of the Social Security Act; and

"(B) the experiment or demonstration is not inconsistent with the purposes of this title.

"(d)(1) The percentage limit referred to in subsection (a)(3)(B) for a hospital's accounting period is equal to the sum of—

"(A) the product of (i) the fraction of the accounting period that occurred before the first day of the transition period, and (ii) the national average percentage increase in community hospital costs per discharge (described in subsection (a)(3)(A)) from the midpoint of the base accounting period to the first day of the transition period; and

"(B) the product of (i) the fraction of the accounting period that occurred after the first day of the transition period, and (ii) the sum of (I) the percent increase in the labor-related expenses of the hospital (as defined in paragraph (2)(A)) for the accounting period, and (II) the percent increase in the nonwage market-

basket of the hospital (as defined in paragraph (2)(B)) for the accounting period.

"(2) As used in paragraph (1):

"(A) The term 'percent increase in labor-related expenses' means, for a hospital for an accounting period (or portion thereof), the product of—

"(i) the average percentage increase in the labor-related expenses paid by that hospital in the period over the labor-related expenses paid by the hospital in the preceding period per employee per hour to employees (other than to supervisors (as defined in section 2(12) of the National Labor Relations Act)) of the hospital; and

"(ii) the average fraction (as computed by the Secretary from time to time) of that hospital's expenses attributable to such labor-related expenses.

In order to provide hospitals with an estimate of the prospective payment limits established under this subpart in advance of each accounting period (or portion thereof) subject to such limits, the Secretary, in estimating the average percentage increase in labor-related costs referred to in clause (i), shall, at the election of each hospital, either use the hospital's estimate of the average percentage increase in such costs that the

hospital anticipates will occur or use the Secretary's estimate of the average percentage increase in such labor-related costs that will occur for the average hospital nationwide during the hospital's accounting period.

"(B) The term 'percent increase in the nonwage marketbasket' means, for an accounting period for a hospital, the sum of the products of—

"(i) the average percentage increase in the United States in the price of each appropriate class (as estimated by the Secretary prospectively before the beginning of the accounting period or, if greater and at the option of the hospital, as determined by the Secretary retrospectively at the end of the accounting period) of goods and services (other than those for services related to labor-related expenses described in subparagraph (A)(i)) in the period over the price of the class in the preceding accounting period; and

"(ii) the average fraction (as computed by the Secretary from time to time) of that hospital's expenses attributable to that class of goods and services.

The Secretary shall compute the fractions described in clause (ii) in a manner such that the sum of such frac-

tions and the average fraction described in subparagraph (A)(ii) is equal to one.

"(e)(1)(A) If for a hospital's accounting period subject to this subpart the number of discharges exceeds the base number of discharges described in paragraph (2), then the prospective payment limits for discharges in the hospital in the subsequent accounting period shall be reduced by such amounts as may be necessary to provide that, in the aggregate for all discharges, the total revenues otherwise permitted under this subpart for the hospital will be reduced, in the aggregate, by 60 per centum of the product of (i) the prospective payment limit established under this subpart for discharges in that previous accounting period classified within the diagnosis-related group with the median weighting factor, and (ii) the number of such excess discharges for that previous accounting period.

"(B) If for a hospital's accounting period subject to this subpart the number of discharges is less than the base number of discharges described in paragraph (2), then the Secretary may, at the request of the hospital, provide that the prospective payment limits for discharges in the hospital in the subsequent accounting period shall be increased by such amounts as may be necessary to assure the hospital receipt of revenues sufficient to reasonably cover overhead costs.

"(2) For purposes of paragraph (1), the base number of discharges for a hospital is equal to the number of discharges in such hospital for the hospital's base accounting period (or, if higher, the average annual number of admissions to such hospital for the hospital's three accounting periods ending with such base accounting period), increased by a percentage equal to the estimated national average percentage increase in discharges to community hospitals during the period between the end of the hospital's base accounting period and the first day of the transition period.

"(3) An adjustment shall not be made under paragraph (1)(A) to the extent that a hospital can demonstrate that a net increase in discharges is attributable to inpatients who, on the date of admission, are entitled to benefits under title XVIII of the Social Security Act or to medical assistance under a State plan approved under title XIX of such Act.

"(4) The Secretary may by regulation provide for a lower percentage than the 60 per centum specified in paragraph (1)(A) in those cases where the Secretary determines that the increase in the number of discharges in a hospital—

"(A)(i) is extraordinary and is due to circumstances beyond the hospital's control, or (ii) is required to improve access to care; and

"(B) results in a ratio of revenues to costs per excess discharge which is greater than 40 per centum

of the ratio of revenues to costs for discharges in the base accounting period.

"EXCEPTIONS

"SEC. 2123. (a) The Secretary, at the request of a hospital and at the Secretary's discretion, may increase the allowable revenues for an accounting period or provide for an increase in the base number of discharges otherwise permitted under this subpart to allow for higher revenues than would otherwise be permitted under the following conditions, pursuant to regulations established by the Secretary:

"(1) A major renovation or replacement of physical plant or significant change in the capacity of the hospital has occurred, which renovation, replacement or change either (A) has been approved by the State health planning and development agency (or other appropriate agency of the State) or (B) is exempt from such approval under law consistent with title XV of the Public Health Service Act, but only to the extent that this renovation or replacement increases capital costs more than the otherwise allowable percentage increase and to the extent that, and for such reasonable period as, these changes increase per discharge operating costs as a result of temporarily underutilized capacity.

"(2) The hospital is a sole community provider or provides a disproportionate percentage of its services (in comparison with facilities of similar size and urban or rural location) to low income or medicare patients, the hospital would otherwise be insolvent, and the State health planning and development agency (or other appropriate State agency) for the hospital has determined that the hospital should be maintained, but only to the extent that the revenues permitted are below the cost of efficiently operating the hospital.

"(3) A larger revenue increase is needed as a result of the special needs and circumstances of the hospital because it is a regional tertiary care institution, teaching hospital, or children's hospital.

"(4) Taking into account the outlier policy established under clauses (i) and (ii) of section 1886(d)(5)(A) of the Social Security Act and the relative severity of cases within classifications of diagnosis-related groups, there has been a significant change in the characteristics of the hospital's mix of patients classified within one or more diagnosis-related groups from those characteristics for patients in the hospital's base accounting period.

"(b) The Secretary may not increase the allowable revenues per discharge under the circumstances described in

subsection (a) unless the circumstances justifying the exemption have been reviewed by the local Health Systems Agency (where one exists) and approved by the State health planning and development agency (or other appropriate agency of the State) as being consistent with the health plan for the area in which the hospital is located or unless such review or approval is not required consistent with title XV of the Public Health Service Act. In applying such exceptions to individual hospitals, the Secretary shall take into account the ability of the hospital to meet its costs through its own resources.

"(c) The Secretary may include in revenues for inpatient hospital services revenues from outpatient hospital services which were customarily rendered on an inpatient basis by the hospital during the base accounting period if the patient receiving such outpatient services was an inpatient during the period immediately preceding or following the rendering of such outpatient services, or may provide for such adjustment of the weighting factors established under section 2122(b)(2) for discharges classified in diagnosis-related groups affected by such a shifting as may be appropriate. A reduction effected under this paragraph shall be made on a pro rata basis in cases where the discontinued services are no longer furnished for a part of an accounting period.

"CIVIL PENALTY

"SEC. 2124. (a)(1) If the Secretary determines that—

"(A) the total inpatient revenues of a hospital for an accounting period exceed the applicable limit for the hospital for the accounting period under this subpart; and

"(B) subject to paragraph (2)(B), the hospital fails to deposit an amount equal to the amount of such excess revenues in an escrow account (established and maintained pursuant to paragraph (3)) and fails to withdraw the amount before the end of the succeeding accounting period pursuant to paragraph (3)(B),

the hospital is subject to a civil penalty of 150 per centum of the difference between (i) the amount of the excess described in subparagraph (A), and (ii) subject to paragraph (2)(B), the amount deposited with respect to such excess in the escrow account and withdrawn pursuant to paragraph (3)(B).

"(2)(A) A hospital which has established an escrow account pursuant to paragraph (3) and withdraws an amount from such account in a manner not permitted under paragraph (3)(B), is subject to a civil penalty in an amount equal to 150 per centum of the amount so withdrawn.

"(B) A hospital which has established an escrow account pursuant to paragraph (3) and has a balance in such account after the end of its last accounting period to which either part A or this part (or both) applies, is subject to a civil

penalty in an amount equal to the amount remaining in such account.

"(3)(A) In order to avoid liability for a civil penalty under paragraph (1), a hospital which has total inpatient revenues for an accounting period in excess of its applicable limit under this title may establish, in a manner prescribed by the Secretary, an escrow account for the deposit of amounts with respect to one or more of the hospital's accounting periods for which the hospital has excess inpatient revenues.

"(B) If the Secretary certifies that the total inpatient revenues of a hospital for an accounting period subject to a limit fall below the applicable limit established under this title for that accounting period, the hospital may withdraw from any escrow account (described in subparagraph (A)) previously established an amount determined by the Secretary to be equal to the amount by which the inpatient revenues of the hospital for that accounting period could be increased without causing the hospital's total inpatient revenues for that accounting period to exceed the applicable limit established under this title for that accounting period.

"(b) If the Secretary determines that a physician or other person or entity (other than a hospital) has charged any person or entity for a service provided to a hospital inpatient, which service is required by law to be billed to a hospital,

such physician or other person or entity shall be charged a civil money penalty of 150 per centum of the amount billed.

"(c)(1) The civil penalties provided under subsection (a) or (b) shall be assessed by the Secretary only after the hospital, person, or other entity has been provided written notice and opportunity for a hearing on the record at which the hospital, person, or other entity is entitled to be represented by counsel, to present witnesses, and to cross-examine witnesses against the hospital, person, or other entity.

"(2)(A) A hospital, person, or other entity adversely affected by an assessment by the Secretary under subsection (a) or (b) may obtain a review of such assessment in the United States court of appeals for the circuit in which the involved hospital, person, or entity is located by filing in such court, within sixty days following the date the hospital, person, or other entity is notified of the Secretary's determination as to the assessment, a written petition requesting that the assessment be modified or set aside. A copy of the petition shall be transmitted by the clerk of the court to the Secretary, and the Secretary shall file in the court the record in the proceeding as provided in section 2112 of title 28, United States Code. Upon such filing, the court shall have jurisdiction of the proceeding and of the question determined in such proceeding, and shall have the power to make and enter upon the pleadings, testimony, and proceedings set forth in such

records a decree affirming, modifying, remanding for further consideration, or setting aside, in whole or in part, the assessment of the Secretary and enforcing the assessment to the extent that such order is affirmed or modified.

"(B) No objection that was not raised before the Secretary shall be considered by the court, unless the failure or neglect to raise such objection is excused by the court because of extraordinary circumstances.

"(C) The findings of the Secretary with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall be conclusive.

"(D) If any party applies to the court for leave to adduce additional evidence, and shows to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the hearing before the Secretary, the court may order such additional evidence to be taken before the Secretary and to be made a part of the record. The Secretary may modify previous findings as to the facts, or make new findings, by reason of additional evidence so taken and filed, and the Secretary shall file such modified or new findings, and the Secretary's recommendations, if any, for the modification or setting aside of the original order. Any such modified or new findings with respect to questions of fact, if supported by substantial evidence on the record considered as a whole, shall

be conclusive. Upon the filing of the record with the court, the jurisdiction of the court shall be exclusive and its judgment and decree shall be final, except that such judgment shall be subject to review by the Supreme Court of the United States, as provided in section 1254 of title 28, United States Code.

"(3)(A) Civil penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in the United States district court for the district in which the involved hospital is located. Amounts recovered shall be deposited as miscellaneous receipts of the Treasury of the United States. The amount of such penalty, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States to the hospital, person, or other entity against which the penalty has been assessed.

"(B) Except as provided in subsection (d), a determination by the Secretary to assess a penalty under this section shall be final upon the expiration of the sixty-day period referred to in paragraph (2)(A) unless the hospital, person, or other entity against which the penalty has been assessed files for a review of such assessment as provided in subsection (d). Matters that were raised or that could have been raised in a hearing before the Secretary or in an appeal pursuant to

paragraph (2) may not be raised as a defense to a civil action by the United States to collect a penalty assessed under this section.

"(d)(1) Any hospital dissatisfied with a determination made on behalf of the Secretary under this section may obtain a hearing before the Provider Reimbursement Review Board (established under section 1878(h) of the Social Security Act and hereinafter in this subsection referred to as the 'Board') if the amount in controversy is $10,000 or more and the request for such hearing is filed within one hundred and eighty days after the date the notice of the determination was provided.

"(2)(A) The provisions of subsections (c), (d), (e), (f), and (i) of section 1878 of the Social Security Act shall apply to hearings provided under paragraph (1). In addition, the Board shall have the power to affirm or reverse any final determination (described in paragraph (1)) of a fiscal intermediary or another entity acting on behalf of the Secretary.

"(B) After completing a hearing provided under paragraph (1) with respect to a determination, the Board shall render its decision on the determination not later than sixty days after the last day of the hearing.

"(3) In addition to the members appointed under section 1878(h) of the Social Security Act, the Secretary shall appoint four additional members to the Board, each of whom

shall be a member of the general public and a representative of consumers of inpatient hospital services. Those provisions of section 1878(h) of such Act which relate to compensation and terms of office of members of the Board shall also apply to members appointed under this paragraph.

"IMPROPER ADMISSIONS PRACTICES

"SEC. 2125. (a) A hospital may not engage in an admission practice that results in—

"(1) a refusal to admit a patient because the patient is unable to pay for inpatient hospital services provided by the hospital or with respect to whom payment is (or is likely to be) less than the anticipated charges for or costs of services provided to the patient;

"(2) the refusal to admit a patient who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital; or

"(3) the refusal to provide emergency services to any person who is in need of emergency services if the hospital provides such services.

"(b) The Secretary shall monitor, on a periodic basis, the extent of each hospital's compliance with subsection (a).

"(c)(1) Upon written complaint by any hospital or upon receiving such volume of written complaints or such reasonable documentation from any persons (as the Secretary finds

sufficient) that a hospital's admission practice violates subsection (a), the Secretary shall investigate the complaint and, upon a finding by him that the complaint is justified, the Secretary may—

"(A) exclude the hospital from participation in any or all of the programs established by title XVIII or XIX of the Social Security Act; or

"(B) reduce the total amounts otherwise reimbursable to the hospital under title XVIII or XIX of the Social Security Act in an amount equal to $3,000 for each of the number of persons who were not admitted as patients or provided services.

"(2) In addition, the Secretary may take any other action authorized by law (including an action to enjoin such a violation brought by the Attorney General upon request of the Secretary) which will restrain or compensate for a violation of subsection (a).

"(d) Any hospital aggrieved by a determination of the Secretary under subsection (c) shall, upon timely request, be entitled to a hearing on the record on such determination (in accordance with section 554 of title 5, United States Code), and no reduction in reimbursement may be made under subsection (c)(1)(B) with respect to a hospital until the hospital has had the opportunity for such a hearing and judicial

review (under chapter 7 of such title) on the determination after the hearing.

"(e) Nothing in this section shall restrict any right which any person (or class of persons) may have under any other statute or at common law to seek enforcement of this Act or to seek any other relief.

"(f) This section shall apply to individuals admitted, or seeking admission, to a hospital on or after the beginning of the transition period (as defined in section 2141(7)).

"ADMINISTRATION OF SUBPART

"SEC. 2126. The Secretary shall, to the extent the Secretary deems it practicable, provide for administration of this subpart through fiscal intermediaries with contracts under section 1817 of the Social Security Act.

"Subpart II—Post-Transition Period

"FEDERAL OPERATION OF STATE HEALTH CARE PLANS

"SEC. 2131. In the case of any State which does not have a State plan approved under section 2102 and in effect for any period beginning after the transition period, the Secretary shall establish and implement a health care plan for such State for such period which meets the requirements of subsections (b), (c), and (d) of section 2103; except that, in implementing a plan under this section—

"(1) for the purpose of determining the definition of 'percentage limit' referred to in subsection (b)(1)(C),

and limited in subsection (c)(3)(B), of such section, '1 percentage point plus' shall be deemed to have been stricken from section 1886(b)(3)(B) of the Social Security Act;

"(2) '40 per centum' shall be substituted for 'one-half' in subsection (b)(1)(D)(i) of such section;

"(3) the Secretary shall provide for a method of hospital revenue limits that meets the requirements of subsection (d) of such section; and

"(4) the Secretary shall provide for such hospital inpatient revenue levels as may be required under section 2102(d)(4).

"PART C—DEFINITIONS AND COMPETITIVE PROVISIONS

"DEFINITIONS

"SEC. 2141. For purposes of this title:

"(1) The term 'eligible organization' has the meaning given such term in section 1876(b) of the Social Security Act.

"(2) The term 'hospital' means, with respect to any period, an institution that satisfied paragraphs (1) and (7) of section 1861(e) of the Social Security Act during all of the period, but does not include any such institution if it—

"(A) does not impose charges or accept payments for services provided to patients,

"(B) is a Federal institution during any part of the period,

"(C) derived 75 per centum or more of its inpatient care revenues from one or more eligible organizations during the preceding twelve months, or

"(D) is a psychiatric hospital (as described in section 1861(f)(1) of such Act) or a rehabilitation hospital (as defined for purposes of section 1886(d)(1)(B)(ii) of such Act).

"(3) The term 'inpatient hospital services' has the meaning given such term in section 1861(b) of the Social Security Act.

"(4) The terms 'health systems agency' and 'State health planning and development agency' mean, for a hospital, such agencies as designated under sections 1515 and 1521, respectively, of this Act for the area or State, respectively, in which the hospital is located.

"(5)(A) The terms 'medicaid' and 'medicaid program' refer to the plans of States approved, or the program, under title XIX of the Social Security Act and the terms 'medicare' and 'medicare program' refer to the program under title XVIII of such Act.

"(B) The terms 'medicare patient' and 'medicaid patient' refer to a patient who is entitled to benefits

under part A of the medicare program or to medical assistance under the medicaid program, respectively.

"(6) The term 'physicians' services' has the meaning given such term in section 1861(q) of the Social Security Act.

"(7) The term 'transition period' means the twenty-four month period beginning January 1985.

"(8) The term 'wage-related expenses' means wages (as such term is used under the Fair Labor Standards Act of 1938) and includes overtime wages and shift differentials, taxes imposed by section 1401, 3101, or 3111 of the Internal Revenue Code of 1954 (relating to the Federal Insurance Contributions Act taxes), and expenses relating to unemployment compensation, workmen's compensation, and fringe benefits (including pensions and health benefits) as established by the Secretary by regulation.

"REVIEW OF TECHNOLOGIES AND PROCEDURES

"SEC. 2142. (a)(1) There is hereby established an Advisory Committee on Health Care Technologies and Procedures (hereinafter in this section referred to as the 'Advisory Committee'), to be composed of fifteen individuals, including individuals who are distinguished in the fields of medicine, engineering, or science (including social science), representatives of business entities engaged in the development or pro-

duction of health care technology, physicians, individuals distinguished in the fields of economics, law, and bioethics, and individuals who are members of the general public who represent the interests of consumers of health care.

"(2) The Secretary shall request the Institute of Medicine of the National Academy of Sciences to appoint members to the Advisory Committee and to supervise the administrative operations of the Advisory Committee under an arrangement under which the actual expenses incurred by the Institute in assisting the Advisory Committee will be paid by the Secretary as an administrative cost of the operations of title XVIII of the Social Security Act. If the Institute is unwilling to enter into such an arrangement, the Secretary shall appoint the members and provide for the supervision of the administrative operations of the Advisory Committee.

"(3) Members shall first be appointed to the Advisory Committee not later than one hundred and twenty days after the date of the enactment of this title.

"(b)(1) The Advisory Committee shall examine the appropriateness of the various interventions and the conditions under which they are needed, the safety and efficacy of alternative therapeutic and preventive regimens, and the standards for availability and utilization of various technologies, and shall publicly report on whether or not payments should

be made for such services and, if so, under what conditions and frequency of service.

"(2) In carrying out its responsibilities, the Advisory Committee shall give priority to expensive interventions and to approaches which may constitute ways of reducing the use of expensive interventions and which hold promise of preventing disease and promoting health.

"(c)(1) Members of the Advisory Committee who are not officers or employees of the United States shall receive for each day they are engaged in the performance of the functions of the Advisory Committee compensation at rates not to exceed the daily equivalent of the annual rate in effect for grade GS–18 of the General Schedule, including traveltime; and all members, while so serving away from their homes or regular places of business, may be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as such expenses are authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently.

"(2) If the Advisory Committee is not operated through an arrangement with the Institute of Medicine, the Secretary shall make available to the Advisory Committee such staff, information, and other assistance as it may require to carry out its functions.

"(d) The Advisory Committee shall be subject to the Federal Advisory Committee Act, except that the Advisory Committee shall terminate twenty-seven months after the month in which this title is enacted.

"EXCEPTIONS FOR HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

"SEC. 2143. (a) The limits established under this title on revenues and discharge of a hospital (including any rates established under State plans under part A) shall not apply to revenues and discharges attributable to individuals enrolled in the organization if—

"(1) the organization elects such treatment, or

"(2) the organization pays in a calendar year for more than 20 per centum of the number of bed-days of care with respect to that hospital.

"(b)(1) Nothing in this title shall be construed as limiting or restricting the right of an eligible organization to negotiate rates of payment with hospitals or physicians furnishing physicians' services to inpatients of hospitals, except that a State must require eligible organizations which make payment for services furnished to inpatients of a hospital to pay a proportional share of unreimbursed costs of providing care to hospital inpatients.

"(2) In the case of a State at least 50 per centum of the population of which is enrolled with an eligible organization,

clause (iii) of section 2103(b)(2)(A) shall not apply and there shall be included (in computing revenues per discharge under State health care plans) the revenues paid by, and discharges attributable to, eligible organizations.".

HEALTH MAINTENANCE ORGANIZATION AND COMPETITIVE MEDICAL PLAN PROVISIONS

SEC. 3. (a) Section 1310(a) of the Public Health Service Act (42 U.S.C. 300e–9(a)) is amended by adding at the end the following new paragraphs:

"(3)(A) Except as provided in subparagraphs (B) and (C), any employer or State or political subdivision thereof described in paragraph (1) shall provide that if—

"(i) the employer, State, or political subdivision makes a contribution with respect to the costs of a health benefits plan with respect to an individual, and

"(ii) the employer offers the option of membership in a qualified health maintenance organization or with an eligible organization described in section 1876(b) of the Social Security Act, which membership provides benefits at least actuarially equivalent to those provided under the other health benefits plan,

the employer, State, or political subdivision (I) shall provide for payment of a contribution toward the membership with such organization in a dollar amount equal to at least the maximum amount of the employer's, State's, or subdivision's

dollar contribution with respect to the other health benefits plan, (II) shall provide, if the dollar contribution with respect to any other health benefits plan exceeds the cost of membership with the organization, the employer, State, or subdivision, for a cash rebate equal to not less than 50 per centum of the dollar amount of such excess, and (III) shall provide information to employees that reasonably compares the different benefits and costs associated with the different plans offered the employees. This paragraph shall not require that the amount of the contribution of an employer, State, or political subdivision with respect to different individuals be the same or that the amount of the contribution with respect to health benefits plans providing for coverage only of individuals (and not of family members) be the same as the contribution for coverage of individuals and family members.

"(B) On the request of an employer, employee, health benefits or competitive medical plan, a collective bargaining representative or other employee representative referred to in paragraph (2), or other interested party, the Secretary shall provide a formula to adjust prospectively the amount of the cash rebate made with respect to membership in an organization to the extent to which it is determined that the individuals enrolled with such organizations in the prior year are not substantially representative of the individuals covered under the other health benefits plans offered. To the extent practi-

cable, such adjustment shall be made so as to take into account the average per capita cost (adjusted to as to reflect actuarial equivalence or experience as described in section 1876(a) of the Social Security Act) of providing health care benefits to the different classes of enrollees. This subparagraph shall not require entities employing in a calendar quarter an average of fewer than one thousand employees in a health service area to provide for such an adjustment.

"(C) Subparagraph (A) shall not apply with respect to employees of a employer, State, or political subdivision who are represented by a collective bargaining representative or other employee representative designated or selected under any law.

"(4) In the case of an entity employing in a calendar quarter an average of one thousand or more employees in a health service area and required to offer the option of enrollment in health maintenance organizations under paragraph (1), the entity shall (notwithstanding subsection (b) and except as provided in paragraph (2)) make available such option with respect to all qualified health maintenance organizations which have indicated (in a manner specified by the Secretary) a desire to be made available with respect to employees of such an entity, except that an employer shall not be obligated under this paragraph to make such option avail-

able with repect to more than six qualified health maintenance organizations.''.

(b) The amendments made by this section shall apply to calendar quarters beginning on or after January 1, 1985.

MEDICARE PAYMENT PROVISIONS

SEC. 4. (a)(1) Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended, in the matter before paragraph (1), by striking out ''section 1876'' and inserting in lieu thereof ''sections 1876 and 1886(h)''.

(2)(A) Section 1876(a)(1)(C) of such Act (42 U.S.C. 1395mm(a)(1)(C)) is amended by inserting ''(or, in the case of individuals enrolled with an eligible organization in a State, or geographic area in a State, in which at least 30 per centum of the individuals eligible to be enrolled with such an organization are so enrolled, 100 per centum)'' after ''95 per centum''.

(B) Section 1876(f) of such Act (42 U.S.C. 1395mm(f)) is amended—

(i) by striking out ''or under a State plan approved under title XIX'' in paragraph (1), and

(ii) by adding at the end the following new paragraph:

''(3) The requirement of paragraph (1) shall not apply to eligible organizations which are public entities or which are offered by a State where the State has established a struc-

tured program under which information on competing eligible organizations offering enrollment in the State is provided to individuals eligible to enroll with the organizations.''.

(C) Section 1903(m)(2) of such Act (42 U.S.C. 1396b(m)(2)) is amended—

(i) by striking out ''(I)'' and all that follows through ''or (II)'' in subparagraph (A)(ii), and

(ii) by amending subparagraph (D) to read as follows:

''(D) Subparagraph (A)(ii) shall not apply with respect to a health maintenance organization which is a public entity.''.

(b)(1) Subsection (c) of section 1886 of such Act (42 U.S.C. 1395ww) is amended to read as follows:

''(c) The Secretary shall provide that in the case of a State health care plan approved under section 2103 of the Public Health Service Act, payments with respect to services covered under such plan in the State—

''(1) may, at the option of the State, or

''(2) in the case of such a plan which provides for control of hospital costs through a ratesetting mechanism established under State law and described in section 2103(d) of such Act, shall

be made in accordance with such plan rather than in accordance with the other provisions of this title.''.

(2) The amendment made by paragraph (1) shall not apply, in the case of plans approved under section 1886(c) of the Social Security Act as of January 1, 1985, for payments to hospitals until January 1, 1986.

(c)(1) Subsection (d)(5) of such section is amended by adding at the end the following new subparagraphs:

"(E) MARGINAL COST ADJUSTMENT FOR INCREASED ADMISSIONS.—(i) The Secretary shall make such adjustment in the payments under paragraph (1) as may be necessary to provide that, to the extent that the number of admissions for an accounting period exceed the base number of admissions described in clause (ii), the payments per discharge shall be equal to 40 per centum (or 50 per centum, with respect to discharges from hospitals subject to a State plan approved under part B of title XXI of the Public Health Service Act) of the payments per discharge otherwise provided under this subsection (other than under this subparagraph). The Secretary may, in the Secretary's discretion, provide for an appropriate adjustment in the payments per discharge otherwise provided under this subsection, in the case of a decrease in the number of admissions below the base number of admissions described in clause (ii), in order to assure the hospital receipt of revenues sufficient to reasonably cover overhead costs.

"(ii) For purposes of clause (i), the 'base number of admissions' for a hospital is equal to the number of admissions to such hospital for the hospital's accounting period ending in calendar year 1983 (or, if higher, the average annual number of admissions to such hospitals for the hospital's three accounting periods ending with such accounting period), increased by a percentage equal to the estimated national average percentage increase in admissions to community hospitals during the period between the end of such accounting period and the first day of the transition period (as defined in section 2141(7) of the Public Health Service Act).

"(iii) An adjustment shall not be made under the first sentence of clause (i) to the extent that a hospital can demonstrate that a net increase in admissions is attributable to inpatients who, on the date of admission, are not entitled to benefits under title XVIII of the Social Security Act or to medical assistance under a State plan approved under title XIX of such Act.

"(iv) The Secretary may by regulation provide for a higher percentage than the percentage specified in clause (i) in those cases where the Secretary determines that the increase in the number of admissions to a hospital—

"(I) is extraordinary and is due to circumstances beyond the hospital's control, or is required to improve access to care; and

"(II) results in a ratio of revenues to costs per excess admission which is greater than percentage specified in clause (i) of the ratio of revenues to costs for admissions in the base period.

"(F) The Secretary also may provide for such adjustments to the payment for subsection (d) hospitals as may be appropriate to take into account exceptional circumstances described in section 2103 of the Public Health Service Act under the conditions described in that section.".

(2)(A) The amendment made by paragraph (1) shall apply to discharges occurring on or after January 1, 1985.

(B) In the case of a hospital reporting period which begins before January 1, 1985, and ends after such date, the Secretary of Health and Human Services shall provide that the amendment made by paragraph (1) shall apply to such a period in such a prorated manner as to be consistent with subparagraph (A).

(e) Subsection (e)(1) of such section is amended—

(1) by inserting "and shall not take into account any adjustment made under subsection (d)(5)(E)" before the period at the end of subparagraph (A), and

(2) by striking out the period at the end of subparagraph (B) and inserting in lieu thereof a semicolon and the following:

"except that the adjustment made under this subparagraph shall not take into account any adjustment made under subsection (d)(5)(E).".

(f)(1) Subsection (a)(4) of such section is amended by striking out ", with respect to costs incurred in cost reporting periods beginning prior to October 1, 1986,".

(2) Subsection (b)(3)(B) of such section is amended by striking out "but excluding nonoperating costs" and inserting in lieu thereof "and including capital costs".

(3) Subsection (g) of such section is amended to read as follows:

"(g) CAPITAL REIMBURSEMENT.—(1)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the capital-related costs of inpatient hospital services of a subsection (d) hospital (as defined in subsection (d)(1)(B)) for inpatient hospital discharges in a cost reporting period beginning on or after January 1, 1985, is equal to the regionally adjust capital-related prospective payment rate determined under paragraph (2) for such discharges.

"(2) The Secretary shall determine a regionally adjusted capital-related prospective payment rate, for each inpatient hospital discharge involving inpatient hospital services of a subsection (d) hospital located in a region of the United States, as follows:

"(A) DETERMINATION OF BASE.—The Secretary shall determine the weighted average payment made, per discharge, for capital-related costs for inpatient hospital services in subsection (d) hospitals during the five fiscal-year period ending with fiscal year 1983.

"(B) UPDATING THE AMOUNT.—The Secretary shall update the amount determined under subparagraph (A) by the compounded sum of the applicable percentage increase (as defined in subsection (b)(3)(B)) for each fiscal year after fiscal year 1983 and before the fiscal year concerned.

"(C) COMPUTING DRG-SPECIFIC RATES.—For each discharge classified within a diagnosis-related group, the Secretary shall establish a capital-related payment rate equal to the product of—

"(i) the updated amount (computed under subparagraph (B), and

"(ii) the capital-related weighting factor (determined under paragraph (3)(A)) for that diagnosis-related group.

"(D) ADJUSTING FOR DIFFERENT REGIONAL CONSTRUCTION COSTS.—The Secretary shall adjust the proportion (as estimated by the Secretary from time to time), of hospitals' capital-related costs which are attributable to construction and construction-related

costs, of the rate determined under subparagraph (C) for hospitals located in each region (as defined for purposes of subsection (d)) for regional differences in construction and construction-related costs by a factor (established by the Secretary) reflecting the relative costs of construction in the geographic region compared to the national average costs of contruction. Such adjustment shall be made in a manner that does not result in any net increase or decrease in the amount of payments otherwise made under this subsection.

"(E) ADJUSTMENT FOR CHANGES IN NUMBERS OF DISCHARGES.—The Secretary also shall provide for an adjustment to reflect a change in the number of discharges in each hospital in the same manner as such adjustment is made to payments under subsection (d) pursuant to paragraph (5)(D) thereof.

"(3)(A) For each diagnosis-related group established under subsection (d)(4)(A) the Secretary, taking into account data on State experience with capital-related reimbursement systems, shall assign an appropriate capital-related weighting factor which reflects the relative capital-related hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

"(B) The Secretary shall adjust the weighting factors established under subparagraph (A) at least every four fiscal

years to reflect changes in the classifications established under subsection (d)(4)(A) and to reflect changes in which factors which may change the relative use of capital-related hospital resources.

"(C) The Commission (established under subsection (e)(2)) shall consult with and make recommendations to the Secretary with respect to the need for adjustments under subparagraph (B), based on its evaluation of scientific evidence with respect to new practices and new technology. The Commission shall report to the Congress with respect to its evaluation of any adjustments made by the Secretary under subparagraph (B).

"(4)(A) If a subsection (d) hospital can demonstrate to the Secretary that the amount of payment otherwise made for capital-related costs for inpatient hospital services under this subsection is significantly less than the amount needed to pay interest, principal, and lease obligations with respect to a capital project either for which obligations were entered into before January 1, 1985, or for which a certificate of need (filed before February 9, 1984) has been approved, the Secretary shall provide for an additional payment as follows:

"(i) For a period of five accounting periods, the additional payment shall be an amount which, in addition to the amount of payment otherwise made under this subsection, would equal the total cash needs with

respect to the interest, principal, and lease payment obligations during that period.

"(ii) For a subsequent period, the Secretary may provide additional payments to the hospital not to exceed, in addition to the amount of payment otherwise made under this subsection, the total cash needs with respect to the interest, principal, and lease payment obligations for that period, but only if the hospital agrees that there will be a reduction in the amount of the payments otherwise made under this subsection for subsequent years such that over the total length of the period there will be no net additional payments under paragraph.

In determining the cash needs of a hospital with respect to a capital expenditure, the Secretary shall take into account the utilization and occupancy level with respect to the facility constructed or improved with the capital expenditure.

"(B) The Secretary shall require, as a condition for the making of additional payments or adjustments in the payment schedule under subparagraph (A), that—

"(i) a hospital must refinance loans related to capital expenditures, if such financing is reasonably available, and

"(ii) if the hospital was acquired after February 1, 1984, the hospital must seek any additional payment

under this paragraph on the basis of the capital-expenditure base (less interest and depreciation) in effect at the time of such acquisition.

"(5)(A) No amounts shall be allowed, under this section or as reasonable costs of providing any item or service under this title, for a return on equity capital for services furnished by or under arrangements with a hospital.

"(B) The Secretary shall provide that in determining the amount which is allowable, with respect to reasonable costs of services furnished by providers of services (other than of inpatient hospital services furnished by hospitals) for which payment may be made under this title, for a return on equity capital for such providers for cost reporting periods beginning on or after January 1, 1985, the rate of return which may be recognized shall not exceed the average of the rates of interest, for each of the months any part of which is included in the reporting period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.".

(4) Subsection (d)(3)(B) of such section is amended—

(A) by inserting "and certain additional capital payments" after "outlier payments",

(B) by inserting before the period at the end the following: "and shall further reduce the amounts by a proportional amount necessary to offset the amount of

the additional payments described in clauses (i) and (ii) of subsection (g)(4)(A)''.

(5) Subsection (e)(1)(B)(i) of such section is amended by inserting ''and not taking into account any reduction under subsection (d)(3)(C) to reflect additional payment amounts under subsection (g)(4)(A)'' after ''section 1866(a)(1)(F)''.

(5) The amendments made by this subsection apply to payments for discharges occurring on or after the first day of the transition period (as defined in section 2141(7) of the Public Health Service Act).

(f) Such section is further amended—

(A) by inserting ''and for medical and other health services furnished to hospital inpatients'' at the end of the heading, and

(B) by adding at the end the following new subsection:

''(h) PHYSICIAN REIMBURSEMENT.—(1) For each diagnosis-related group established under subsection (d)(4), the Secretary shall estimate the average per discharge amount of the charges recognized under part B attributable to items and services furnished to inpatients classified within such group during 1983. Such average shall be determined separately—

''(A) for hospitals in each carrier-charge area established for purposes of section 1842, and

''(B) for all hospitals in the United States.

"(2)(A)(i) Subject to the part B deductible described in section 1833(b) and subject to the succeeding provisions of this subsection, with respect to each individual who is entitled to benefits under part A and enrolled under part B, who is an inpatient of a hospital, and whose discharge from the hospital in a State is classified within a diagnosis-related group established under subsection (d)(4), the Secretary shall provide, in lieu of payments otherwise made under part B for services furnished to the individual as an inpatient of the hospital, for payment to the hospital (or to others, including multispecialty physicians groups, under arrangements with the hospital) of an amount equal to 80 per centum of the amount described in clause (ii).

"(ii) The amount referred to in clause (i) is the applicable combined rate (described in paragraph (3)) determined with respect to such diagnosis-related group under paragraph (1), increased by the applicable percentage increase (described in paragraph (4)) for the State in which the hospital (in which the services were provided) is located and adjusted for variations in certain local costs under paragraph (5).

"(B) With respect to services for which the payment amount is provided under this subsection, instead of the charges which may otherwise be imposed under section 1866(a)(2)(A) with respect to such services, the hospital (or others under arrangements made with the hospital) may

charge an individual or other person (consistent with the provider agreement under section 1866) (i) an amount equal to the amount of the deduction imposed with respect to the services under section 1833(b) and (ii) an amount equal to up to 20 per centum of the amount described in subparagraph (A)(ii) or, in accordance with guidelines issued by the Secretary, such other copayment or other coinsurance amount which provides for a more equitable distribution of coinsurance costs on a per diem or other basis and which, in the aggregate, does not provide for coinsurance in excess of the amounts otherwise provided under this subparagraph.

"(3) For purposes of paragraph (2)(A)(ii), the 'applicable combined rate' is—

"(A) for discharges occurring during the first year of the transition period, 100 per centum of the average described in paragraph (1)(A), for the charge area established under section 1842(b) for the area in which the hospital is located;

"(B) for discharges occurring during the second year of such period, 66⅔ per centum of the average described in paragraph (1)(A), for such charge area, and 33⅓ per centum of the average described in paragraph (1)(B);

"(C) for discharges occurring during the first year after such period, 33⅓ per centum of the average de-

scribed in paragraph (1)(A), for such charge area, and 66⅔ per centum of the average described in paragraph (1)(B); and

"(D) for discharges occurring after the first year after such period, 100 per centum of the average described in paragraph (1)(B).

"(4) For purposes of paragraph (2), the 'applicable percentage increase' for any period for services furnished in a State shall be equal to one percentage point plus the percentage, estimated by the Secretary before the beginning of the period, by which the cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising inpatient hospital services and medical and other health services furnished to inpatients of a hospital in that State (or, if adequate data are not available with respect to that State, in the region in which the State is located or in the United States), based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such services, for the period exceed the cost of such mix of goods and services in the corresponding area for 1983.

"(5)(A) The Secretary shall adjust the amounts otherwise determined under paragraph (2)(A)(ii) so as to take into account area differences relating to wages, utility rates, and other exogenous cost factors.

"(B) The Secretary may provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in the manner described in subsection (d)(5)(B).

"(6)(A) The Secretary shall provide for such exceptions in the payment amounts provided under this subsection as are provided under section 2123(a) of the Public Health Service Act, under the conditions described in that section.

"(B) The Secretary shall provide for an adjustment in the payment amounts provided under this subsection to take into account variations in the number of admissions to the hospital in the same manner as such adjustment is made under subsection (d)(5)(E) for payments amounts under subsection (d)(1).".

(c) The amendments made by subsection (b)(4) shall not apply to discharges of individuals admitted to hospitals before the first date of the transition period (as defined in section 2141(7) of the Public Health Service Act).

REQUIRING PAYMENTS FOR HEALTH CARE SERVICES FURNISHED TO INPATIENTS TO BE MADE TO OR THROUGH A HOSPITAL AS A CONDITION OF THE HOSPITAL'S PARTICIPATION IN THE MEDICARE PROGRAM

SEC. 5. (a) Section 1866(a) of the Social Security Act (42 U.S.C. 1395cc(a)) is amended—

(1) by striking out "Any provider" in paragraph (1) and inserting in lieu thereof "Subject to paragraph (4), any provider", and

(2) by inserting at the end the following new paragraph:

"(4) A hospital shall be qualified to participate under this title and shall be eligible for payments under this title only if it provides (in the agreement filed with the Secretary under paragraph (1) and in a manner satisfactory to the Secretary) that any health care service (including medical and other health services) furnished to a hospital inpatient (whether or not the inpatient is entitled to have payment made with respect to the services under this title) shall be billed only by or through the hospital and payment for such services may only be made to the hospital or to an entity under arrangements (or, with respect to individuals not entitled to benefits under parts A and B of this title, comparable conditions to the arrangements described in section 1861(w)(1)) with the hospital.".

(b) Section 1128A of such Act (42 U.S.C. 1320a–7a) is amended by adding at the end the following new subsection:

"(i) Each physician who furnishes services to an individual for which the individual is otherwise entitled to have payment made under title XVIII is deemed, for purposes of this section, to have agreed not to impose any charge for the

service except on the basis of the terms of an assignment to have accepted an assignment under section 1842(b)(3)(B)(ii).''.

(c) Section 1866(b)(2) of such Act (42 U.S.C. 1395cc(b)(2)) is amended by inserting before the period at the end thereof the following: '', or (H) that such provider (in the case of a hospital) is not complying with the provisions of subsection (a)(4)''.

(d)(1) Section 1842(b)(3)(B) of such Act (42 U.S.C. 1395u(b)(3)(B)) is amended by striking out ''be made—

''(i) on the basis of an itemized bill; or

''(ii) on the basis of an assignment''

and inserting in lieu thereof ''be made only on the basis of an assignment''.

(2) Section 1870(f) of such Act (42 U.S.C. 1395gg(f)) is amended by striking out ''payment for such services has not been made'' and all that follows through the end and inserting in lieu thereof ''payment for such services has not been made, payment for such services shall be made only if the person or persons who furnished the services agree that the reasonable charge is the full charge for the services and only in such amount and subject to such conditions as would be applicable if the individual who received the services had not died.''.

(e)(1) The amendments made by this section shall apply to health care services furnished on or after the first day of the transition period (as defined in section 2141(7) of the Public Health Service Act).

(2) The Secretary of Health and Human Services shall provide for notice to the public and, in particular, to individuals enrolled (or enrolling) under the supplementary medical insurance program under part B of title XVIII of the Social Security Act, of the requirements of section 1866(a)(4) of such Act and of the amendments made by subsections (b) and (d) of this section.

PAYMENTS FROM MEDICARE TRUST FUNDS

SEC. 6. (a) Section 1817 of the Social Security Act (42 U.S.C. 1395i) is amended—

(1) by striking out "prior to January 1988" in subsection (j)(1);

(2) by inserting "and certifies that such Trust Fund can repay within ten years of the date of such borrowing the principal and interest on any amounts so borrowed" in subsection (j)(1) after "Trust Fund" the first place it appears;

(3) by striking out subparagraph (C) of subsection (j)(3); and

(4) by adding at the end thereof the following new subsection:

"(k)(1) All payments made to hospitals for medical and other health services provided to hospital inpatients, as determined in accordance with section 1886(h), shall be made from the Federal Hospital Insurance Trust Fund.

"(2)(A) There shall be transferred periodically to the Federal Hospital Insurance Trust Fund from the Federal Supplementary Medical Insurance Trust Fund, amounts which the Secretary of Health and Human Services determines to be equal to the fraction of the total revenues of the Federal Supplementary Medical Insurance Trust Fund for each fiscal year determined under subparagraph (B).

"(B) The fraction for each fiscal year for purposes of subparagraph (A) is a fraction the numerator of which is the amount paid from the Federal Supplementary Medical Insurance Trust Fund in calendar year 1983 for medical and other health services provided to hospital inpatients, and the denominator of which is the total amount paid from the Federal Supplementary Medical Insurance Trust Fund in calendar year 1983.".

(b) Section 1839 of such Act (42 U.S.C. 1395r) is amended by adding at the end thereof the following new subsection:

"(f) In determining the monthly actuarial rates for purposes of this section, the Secretary shall make such determination on the basis of the payments which would have been

made from the Federal Supplementary Medical Insurance Trust Fund if the amendments to this title made by the Medicare Solvency and Health Care Financing Reform Act of 1984 had not been enacted.''.

(c) Section 1841(g) of such Act (42 U.S.C. 1395t) is amended by inserting '', excluding payments for medical and other health services provided to hospital inpatients'' after ''payments provided for by this part''.

(d) Section 1841 of such Act is further amended by adding at the end thereof the following new subsection:

''(j) There shall be transferred periodically to the Federal Hospital Insurance Trust Fund the amounts required under section 1817(k).''.

STUDIES

SEC. 7. (a) The Secretary of Health and Human Services shall provide for the following studies, and shall promptly report to the Congress on the results of such studies:

(1) How the changing demographic composition of the population of the United States affects the utilization and cost of providing health care services.

(2) How to maintain a high quality of health care services while constraining the rate of increase of costs for those services.

(3) How the amendments made by this Act have affected the delivery, and cost of providing, health care services.

(4) The success of the different State health care plans approved under part B of such title, with particular attention to comparing the relative success and potential for long-term success of plans which are based on mandatory prospective rate regulation, voluntary rate regulation, or competitive models.

(5) The impact of equalizing hospital inpatient revenues per discharge among the States.

(6) The impact and success of the marginal cost adjustment and other incentives provided in this Act to decrease the number of unnecessary admissions to hospitals.

(7) The impact of the amendments made by this Act on medical education, medical research, and technological innovation in the health care sector.

(b) The studies described in subsection (a) shall be conducted, and the reports thereon submitted, in such manner as to provide the Congress with the results of the studies not later than January 1, 1990.

○